DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 8

2. STATE: Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July, 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1932 of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ 0
b. FFY 2003 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 1 to Attachment 2.1A
Pages 1-19

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
NA

10. SUBJECT OF AMENDMENT:
Medicaid Managed Care

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Governor has waived review

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robert J. Seiffert

13. TYPED NAME:
Robert J. Seiffert

14. TITLE:
Medicaid Administrator

15. DATE SUBMITTED:
June 25, 2001

16. RETURN TO:
HHS - Finance and Support
Attn: Margaret Booth
301 Centennial Mall South
Medicaid Division 5th Floor
Lincoln, Nebraska 68509

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
06/29/01

18. DATE APPROVED:
SEP 04 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
07/01/01

20. SIGNATURE OF REGIONAL OFFICIAL:
Timothy A. Weidler for

21. TYPED NAME:
Nanette Foster Reilly

22. TITLE:
Acting
ARA for Medicaid & State Operations

23. REMARKS:
SPA CONTROL
Date Submitted: 06/26/01
Date Received: 06/29/01

cc:
Curtiss
Seiffert

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **Nebraska**

Nebraska Health Connection (NHC)
HMO and PCCM programs

Citation: Section 1932 of the Social Security Act

A. General Description of the Program

1. This program is called Nebraska Health Connection (NHC). All Medicaid beneficiaries as described in Section C are required to enroll in either a managed care organization (MCO), also known as a health maintenance organization (HMO), or a primary care case management (PCCM) program. Those described in Section D are not subject to mandatory enrollment.

2. The objectives of this program are to reduce costs, reduce inappropriate utilization, and ensure adequate access to care for Medicaid recipients.

3. This program is intended to enroll Medicaid recipients in HMOs, which will provide or authorize all primary care services and all necessary specialty services, where the assigned medical practitioner will authorize all primary care services and all necessary specialty services. The HMO/PCCM assigned practitioner will act as the Primary Care Physician (PCP). The PCP is responsible for monitoring the care and utilization of non-emergency services. Neither emergency nor family planning services are restricted under this program.

4. The PCP will assist the participant in gaining access to the health care system and will monitor the participant's condition, health care needs, and service delivery on an ongoing basis. The PCP will be responsible for locating, coordinating, and monitoring all primary care and other covered medical and rehabilitation services on behalf of recipients enrolled in the program.

5. Recipients enrolled under this program will be restricted to receive covered services from the PCP or upon referral and authorization of the PCP or HMO. The PCP will manage the recipient's health care delivery. The NHC program is intended to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will enhance continuity of care and efficient and effective service delivery. This is accomplished by providing the recipient with a choice between at least two PCCM programs or a combination of one HMO and the PCCM program. Recipients will have a minimum of 45 days to make the selection but may change the initial selection at any time. Pregnant woman may only change plans within the first 90 days of enrollment or identification of their pregancy if already enrolled (which ever is the latter) or upon good cause for the duration of the pregnancy plus 60 days. The enrollment broker facilitates this through enrollment

counseling and information distribution so recipients may make an informed decision. (See Section E for more details.)

6. Non-HMO contractors will act as enrollment brokers in assisting eligible recipients in choosing among competing health plans in order to provide recipients with more information about the range of health care options open to them.

7. The state will share cost savings with recipients resulting from the use of more cost-effective medical care with recipients by eliminating co-payments for those who enroll into an HMO

8. The state requires recipients in PCCM to obtain services only from their assigned PCP or through referral to a Medicaid-participating provider who provides such services. Providers must meet reimbursement, quality, and utilization standards that are consistent with access, quality, and efficient and economic provisions of covered care and services. Recipients enrolled in HMO plans may be referred to any HMO-credentialed provider. The plan may also choose to allow non-emergency care to be provided by other practitioners on a case-by-case basis if it benefits the enrollee.

9. PCCM may operate in all counties of the state except in those geographical areas without an adequate number of primary care case managers participating in a PCCM. The HMO and PCCM program will operate in counties where HMOs have contracted with the state. Mandatory assignment will only occur if the recipient has a choice between at least two PCCM PCP or a combination of one HMO and the PCCM program.

B. Assurances and Compliance

1. Consistent with this description, the state assures that all the requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act will be met.

2. The NHC program is available in selected counties in Nebraska. Mandatory enrollment provisions will not be implemented unless a choice of at least two PCCM PCPs or a combination of HMO and the PCCM program is available.

3. Nebraska has safeguards in effect to guard against conflict of interest on the part of employees of the state and its agents.

4. Nebraska will monitor and oversee the operation of the mandatory managed care program, ensuring compliance with all federal program requirements, federal and state laws and regulations, and the requirements of the contracts agreed upon by Medicaid and its contractors.

5. Nebraska will evaluate compliance by review and analysis of reports prepared and sent to the Nebraska Medicaid agency by the contractors. Deficiencies in one or more areas will result in the contractor being required to prepare a corrective action plan,

which will be monitored by the Nebraska Medicaid agency.

6. Reports from the grievance and complaint process will be analyzed and used for evaluation purposes.

7. Nebraska staff will provide technical assistance as necessary to ensure that contractors have adequate information and resources to comply with all requirements of law and their contracts.

8. Nebraska staff will evaluate each contractor for financial viability/solvency, access and quality assurance.

C. Target Groups of Recipients

The NHC program is limited to the following target groups of recipients:

1. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.

2. Recipients eligible for Medicaid through the Medicaid expansion under the State Child Health Insurance Program (SCHIP). (Recipients in the Nebraska's separate SCHIP program are not enrolled in managed health care.)

3. AABD Adults

D. Mandatory Enrollment Exclusions

1. The following groups will not be enrolled in managed care:

   a. Clients with Medicare coverage pursant to 471NAC 3-000;

   b. Clients residing in nursing facilities and receiving custodial care pursuant to 471 NAC 12-000

   c. Clients residing in intermediate care facilities for the mentally retarded (ICF/MR) pursuant to 471 NAC 31-000

   d. Clients who are residing out of state (ie. Children placed with relatives out of state, and who are designated as such by HHSS personnel);

   e. Certain children with disabilities who are receiving in-home services, also known as the Katie Beckett program pursuant to 469 NAC 2-010.01F;

   f. Aliens who are eligible for Medicaid for an emergency condition only pursuant to Titles 468, 469, 477, and 479 NAC.

   g. Clients participating in the refugee resettlement program/medical pursuant to

Title 470 NAC;

h. Clients receiving services through the following home and community based waivers pursuant to Title 480 NAC for:

1 Adults with mental retardation or other related conditions;

2 Aged persons, adults or children, with disabilities;

3 Children with mental retardation and their families;

4 Infants and toddlers with disabilities (a/k/a the Early Intervention Program;

5 Clients receiving Developmental Disability Targeted Case Management Services; and

6 Any other group for whom which the Nebraska HHS System has received approval of a 1915(c) waiver of the Social Security Act.

i. Clients who have excess income (i.e. spenddown – met or unmet) pursuant to 471 NAC 3-000;

j. Clients participating in the Subsidized Adoption Program, including those receiving subsidy from another state pursuant to Title 469 NAC

k. Clients participating in the State Disability Program pursuant to Title 469 NAC

l. Clients eligible during the period of presumptive eligibilty pursuant to 471 NAC 28-000;

m. Transplant recipients pursuant to 471 NAC 10-000;

n. Clients who have received a specific disenrollment/waiver of enrollment from the Nebraska Mediciad Managed Care program.

o. American Indians and Alaskan Natives

p. Clients having other insurance

q. Clients enrolled in another Medicaid Managed Care Program (except the PHP program)

r. Clients who have an eligibility program that is only retro-active.

E. Enrollment and Disenrollment

1. All recipients will be given the opportunity to choose from at least two NHC providers. This will be multiple PCCM providers or a combination of PCCM providers and an HMO option or a choice of HMO's if two or more are available in a county. If a recipient has a prior provider relationship that they wish to maintain, the enrollment broker will assist the recipient in choosing a managed care entity that will maintain this relationship.

   Nebraska contracts with an independent contractor to conduct the enrollment process and related activities. The enrollment broker performs services and supplies information as follows to facilitate the enrollment process:

   a. Review provider access for each county quarterly to assure appropriate primary care access for the enrollees.

   b. Answer NHC-related questions from recipients and providers.

   c. Prepare enrollment materials for NHC program, for Department approval, and store NHC materials (HMO, PCCM and NHC in general).

   d. Process new enrollments and transfers for those NHC eligibles identified by the Department.

   e. Process the recipient's choice of NHC option and send enrollments to the Department for inclusion on the next monthly medical card.

   f. Log grievances and requests for special authorization from NHC enrollees.

   h. Perform various quality assurance activities for the NHC program.

   i. Supply an enrollment packet to the recipients that includes HMO and PCCM materials and information supplied by the state and plans.

   k. Provides enrollment counseling which includes:

      (1) Inquiring about patient/provider experience and preference.

      (2) Providing information on which HMOs or PCCM PCPs are available to maintain a prior patient-provider relationship.

      (3) Facilitating direct contact with individual PCPs, PCCMs and HMOs, as necessary.

      (4) Providing any information and education concerning the enrollment process, individuals', benefits offered, the enrollment packet, client right's and responsibilities and any of the other information provided for

in this section.

1. If the recipient fails to choose an HMO or PCCM PCCM provider within a minimum of 45 calendar days after receiving enrollment materials, the Department assigns the recipient to a PCP in a PCCM or HMO.

2. Default enrollment will be based upon maintaining prior provider-patient relationships, proximity and prior familial/provider relationships.

3. Information in an easily understood format will be provided to beneficiaries on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among managed care entities regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

4. Any selection or assignment of an PCP, HMO or PCCM may be changed at any time, with the exception of pregnant woman who may only change plans within the first 90 days of enrollment or identification of their pregancy if already enrolled (which ever is the latter) or upon good cause for the duration of the pregnancy plus 60 days.

5. Pregnant women will be provided notification 60 days before the end of a lock-in period of their opportunity to make a new choice of HMO or PCCM.

7. Enrollees will be given an opportunity to change PCPs, HMOs or PCCMs and will be sent a notice to that effect.

8. PCPs, HMOs and PCCMs will not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of services.

9. The HMO and PCCMs will not terminate enrollment because of an adverse change in the recipient's health.

10. An enrollee who is terminated from an PCP, HMO or PCCM solely because the enrollee has lost Medicaid eligibility for a period of two months or less will automatically be re-enrolled into the same HMO or PCCM upon regaining eligibility to the extent possible.

11. The recipient will be informed at the time of enrollment of the right to disenroll.

12. An enrollee will be allowed to choose his or her health professional in the HMO to the extent possible and appropriate and will be allowed to change his or her health professional as often as requested per the policy of the HMO. Changes made for good cause are not considered as a request for change if the HMO sets a number of changes allowed yearly.

13. Enrollees will have access to specialists to the extent possible and appropriate and female enrollees will have direct access to women's health services.

F. Process for Enrollment in an HMO/PCCM

The following process is in effect for recipient enrollment in the NHC Program:

1. The Department shall provide beneficiaries with information in an easily understood format on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among MCEs regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

2. All materials will be in an easily understood format (4th grade reading level or less). Materials will be translated into languages Spanish and Vietnamese, and other languages upon request, including braille.

3. Recipients will be able to select an HMO or PCCM from a list of available managed care entities in their service area. If the recipient wishes to remain with a PCP or plan with whom a patient/physician relationship is already established, the recipient is allowed to do so to extent possible. Each recipient shall notify the Department by mail, telephone or in person, of his or her choice of plans. If voluntary selection is not made within the 45 day period describe above, the Medicaid program shall assign a PCP and a HMO or PCCM in accordance with the procedures outlined in E above.

4. As indicated in Section E, if the recipient does not choose a PCP , the Department will assign the recipient to a PCP and notify the recipient of the assignment.

5. The HMO and PCCM will be informed electronically of the recipient's enrollment in that plan.

6. The recipient will be notified of enrollment and issued an identification document.

7. Additionally, each HMO will provide recipients the following information as soon as practicable after activation of enrollment:

   a. Benefits offered, the amount, duration, and scope of benefits and services available.

   b. Procedures for obtaining services.

   c. Names and locations of current network providers, including providers that are not accepting new patients.

   d. Any restrictions on freedom of choice.

   e. The extent to which there are any restrictions concerning out-of-network providers.

   f. Policies for specialty care and services not furnished by the primary care providers.

   g. Grievance and appeal process.

   h. Member rights and responsibilities.

G. Maximum Payments

Section 1902(a)(30) of the Act and implementing regulations prohibit payments to an HMO contractor from exceeding the cost to the agency of providing these same services on a fee-for-service basis to an actuarially equivalent nonenrolled population. Nebraska fee-for-service costs are considered in the development of the upper payment limit and the managed care rates. The contract with the actuary requires that calculated rates shall be actuarially sound and consistent with the upper payment limit requirement at 42 CFR 447.361. State payments to contractors will comply with the upper payment limit provisions in 42 CFR 447.361.

H. Covered Services

1. Services not covered by the NHC program will be provided under the Medicaid fee-for-service program. Medicaid recipients will be informed of the services not covered under the NHC Program, the process for obtaining such services. The State assures that the services provided within the managed care network and out-of plan and excluded services will be coordinated. The required coordination is specified in the state contract with HMOs and PCCMs and is specific to the service type and service provider.

2. HMOs are directed to develop subcontracts or memoranda of understanding with federally qualified health centers (FQHCs) and rural health clinics (RHCs) as well as family planning clinics.

3. Preauthorization of emergency services and emergency post stabilization services and family planning services by the recipient's HMO is prohibited. Recipients will be informed that emergency and family planning services are not restricted under the NHC Program. "Emergency services" are defined in the HMO contract..

4. The PCCM shall be responsible for managing the services marked below in column (7). The HMO capitated contract will contain the services marked below in Column (4). All Medicaid-covered services not marked in those columns will be provided by the Nebraska Plan (under the requirements of that program) or Medicaid fee for service (without referral). Mental health and substance abuse treatment services are provided under the Nebraska Plan for Behavioral Health under the current 1915(b) waiver in effect for those services.

Service (1)	State Plan Approved (2)	HMO/PHP Capitated Reimburse ment (4)	Fee-for-Service Reimburse-ment Impacted by HMO/PHP (5)	Fee-for-Service Reimburse-ment for HMO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Day Treatment Services	X	X			X		
Dental	X			X			X
Detoxification	X	X					X
Durable Medical Equipment	X	X			X		
Education Agency Services	X			X			X
Emergency Services	X	X					X
EPSDT	X	X			X		
Family Planning Services	X			X			X
Federally Qualified Health Center Services	X	X			X		
Home Health	X	X			X		
Inpatient Hospl – Psych	X			X			X

Service (1)	State Plan Approved (2)	HMO/PHP Capitated Reimburse ment (4)	Fee-for-Service Reimburse-ment Impacted by HMO/PHP (5)	Fee-for-Service Reimburse-ment for HMO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Inpatient Hospital – Other	X	X			X		
Immunizations	X	X					X
Lab and X-ray for Medical Surgical Services	X	X			X		
Nurse Midwife	X	X			X		
Nurse Practitioner	X	X			X		
Nursing Facility	X			X			X
Obstetrical Services	X	X			X		
Occupational Therapy	X	X			X		
Other Fee-for-Service Services	X	X			X		
Other Psych. Practitioner	X			X			X
Outpatient Hospital – All Other	X	X			X		
Outpatient Hospital – Lab & X-ray for Medical Surgical Services	X	X			X		
Pharmacy	X			X			X
Physical Therapy	X	X			X		
Physician	X	X			X		
Prof. & Clinic and Other Lab and X-ray	X	X			X		
Psychologist	X			X			X

Service (1)	State Plan Approved (2)	HMO/PHP Capitated Reimburse ment (4)	Fee-for-Service Reimburse-ment Impacted by HMO/PHP (5)	Fee-for-Service Reimburse-ment for HMO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Rehabilitation Treatment Services	X			X			X
Respiratory Care	X	X			X		
Rural Health Clinic	X	X			X		
Speech Therapy	X	X			X		
Substance Abuse Treatment	X			X			X
Testing for Sexually Transmitted Diseases	X	X			X		
Transportation – Emergency	X	X			X		
Transportation - Non-emergency	X	X			X		
Vision Exams and Glasses	X		X				X

I. Mandate

1. In the NHC program, Nebraska will enter into contracts with State licensed HMOs. Nebraska will enter into comprehensive risk contracts with the HMOs. These organizations will arrange for comprehensive services, including inpatient or outpatient hospital, laboratory, x-ray, physician, home health, early periodic screening, diagnosis and treatment, family planning services and all other Medicaid optional services, except for those described in Section H.1.

   All contracts will comply with Sections 1932 and 1903(m) of the Act. All contracts Nebraska has selected the HMOs that operate under the NHC program in the following manner: Nebraska has used and will use an open cooperative procurement process, in which any qualifying HMO that complies with federal procurement requirements and 45 CFR Section 74 may participate. The Department requires all participating HMOs to be licensed by the Nebraska Department of Commerce, Insurance Division. This licensure also identifies the HMO service area, by county in the state. The Department sets the capitation rates by region in the state and any participating HMO must accept those rates for the respective Medicaid covered

services.

2. With respect to the PCCM, the contracts Nebraska enters into with PCPs will contain (at a minimum) all terms required under section 1905(t)(3). Reimbursement will be made on a fee-for-service basis, with a $2.00 monthly case management fee for each PCCM recipient assigned. The following is a list of the types of providers that qualify to be primary care providers under the NHC program: physicians (pediatricians, family practitioners, internists, general practitioners, obstetrician/gynecologists).

   Certified nurse practitioners are not included as a PCP type; however these services will be made available: The Department covers these services in the same manner as fee-for-service. The only difference is that a referral from the PCP provider is required for reimbursement of the services. Any Nebraska Medicaid provider of this type is able to see and treat a NHC recipient with the required referral.

   Nurse midwives are not included as a PCP type, however these services will be made available: The Department covers these services in the same manner as under fee for service. The only difference is that a referral from the PCP is required for reimbursement of the services. Any Nebraska Medicaid provider of this type is able to see and treat a NHC recipient with the required referral.

3. All participating PCPs in the PCCM shall be required to sign a PCCM participation agreement in addition to the standard Medicaid provider agreement and shall be bound by its terms and conditions. Each PCP shall be required to specify the number of recipients the PCPs willing to serve as primary care physician in a number not to exceed the number set forth in Title 482 NAC.

4. PCP under the NHC program must:

   a. Be Medicaid-qualified providers and agree to comply with all applicable federal statutory and regulatory requirements, including those in Section 1932 of the Act and 42 CFR 434 (and new requirements in 42 CFR 438 when final) and all State plan standards regarding access to care and quality of service;

   b. If participating in a PCCM ,sign a contract or addendum for enrollment as a PCP which explains the PCP's responsibilities and complies with the PCCM contract requirements in Section 1905(t)(3) of the Act including: making available 24-hour, 7 days per week access by telephone to a live voice (an employee of the primary care case manager or an answering service) or an answering machine which will immediately page an on-call medical professional for information, referral, and treatment of medical emergencies; referrals for non-emergency services; or to information about accessing services or how to handle medical problems during non-office hours;

   c. Provide or arrange for the provision of comprehensive primary health care

services to all eligible Medicaid beneficiaries who choose or are assigned to the PCP's practice;

d. Refer or have arrangements for sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

e. Have hours of operations that are reasonable and adequate. The PCP must have the same hours of operation for the NHC enrollees as they have for their other patients. The Department requires all PCP's to have 24-hour access via telephone. This does allow for another provider to be on-call for the PCP provider during non-office hours.

f. Not refuse an assignment or disenroll an enrollee or otherwise discriminate against an enrollee solely on the basis of age, sex, race, physical or mental handicap, national origin, or health status or need for health services, except when that illness or condition can be better treated by another provider type;

g. Not have an affiliation with person debarred, suspended, or otherwise excluded from federal procurement activities per Section 1932(d)(1) of the Act;

5. Qualifications and requirements for PCPs are noted in the provider agreements. HMOs and PCCMs shall meet all of the following requirements:

a. An HMO shall be a Medicaid-qualified provider and agree to comply with all pertinent Medicaid regulations and state plan standards regarding access to care and quality of services.

b. The HMO shall sign a certification agreement that explains the responsibilities HMOs must comply with.

c. The HMO shall have a state-approved grievance and appeal process.

d. The HMO or PCCM PCP shall provide comprehensive primary health care services to all eligible Medicaid recipients who choose, or are assigned to, the HMO or PCCM Program.

e. The HMO or PCCM PCP shall refer enrollees for specialty care, hospital care, or other services when medically necessary.

f. The HMO or PCCM shall make available 24-hour, 7-day-a-week access by telephone to a live voice (an employee of the HMO or a representative or a representative of the PCCM) or an answering machine which will immediately direct an enrollee as to how to contact an on-call medical professional, so that referrals can be made for non-emergency services and information can be given

about accessing services or how to handle medical problems during non-office hours.

g. The HMO or PCCM shall not refuse an assignment, disenroll a participant, or otherwise discriminate against a participant solely on the basis of age, sex, physical or mental disability, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type.

h. The HMO or PCCM may request reassignment of the participant to another HMO or PCCM only if the patient/provider relationship meets the provisions set forth in Title 482 NAC. All reassignments must be state-approved.

The Department reviews all reasons for transfer on a quarterly basis via the reports from the enrollment broker. The Department meets with the enrollment broker weekly to review all current issues, including any requests for disenrollment by any PCP, PCCM or HMO.

i. All HMO and PCCM subcontractors shall be required to meet the same requirements as those that are in effect for the contractor.

j. The HMO shall be licensed by the Division of Insurance in the Nebraska Department of Commerce in order to ensure financial stability (solvency) and compliance with regulations.

k. Access to medically necessary emergency services shall not be restricted. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

l. Nebraska ensures enrollee access to emergency services by requiring the HMO/PHP/PCCM to provide adequate information to all enrollees regarding emergency service access.

m. Nebraska ensures enrollee access to emergency services by including in the contract requirements for HMOs/PHPs/PCCMs to cover the following.

(1) The screening or evaluation and all medically necessary emergency services, when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

(2) The screening or evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

(3) Both the screening or evaluation and stabilization services, when a clinical emergency is determined,

(4) Continued emergency services until the enrollee can be safely discharged or transferred,

(5) Post-stabilization services that are pre-authorized by the HMO/PHP or primary care case manager, or were not pre-authorized, but the HMO/PHP or the primary care case manager failed to respond to request for pre-authorization within one hour, or could not be contacted. Post-stabilization services remain covered until the HMO/PHP or primary care case manager contacts the emergency room and takes responsibility for the enrollee.

J. Additional Requirements

1. Any marketing materials available for distribution under the Social Security Act,state statutes and regulations shall be provided to the Department for its review and approval.

2. The HMO shall certify that no recipient will be held liable for any HMO debt as the result of insolvency or for services Nebraska Medicaid will not pay for.

3. The HMO shall include safeguards against fraud and abuse, as provided in state statutes.

4. The HMO shall allow the state to take sanctions as prescribed by federal or state statutes. Also, the HMO shall provide assurance that due process will be provided.

K. FQHC and RHC Services

The program is **mandatory** and the enrollee is guaranteed a choice of either a PCP employed or contracted with an FQHC as a PCP or at least one HMO/PCCM which has at least one FQHC as a participating provider.

All of the FQHCs in the state are participating in the PCCM program. This allows any recipient to be able to select a PCP employed or contracted with an FQHC as the primary care case manager. In addition, the HMO contract specifically mentions the encouragement to contract with FQHCs in the service area. FQHC reimbursement will follow all applicable federal requirements. The HMOs must pay FQHCs and RHCs rates comparable to non-FQHC and RHC providers. Nebraska State Medicaid Plan provides for the prospective payments to FQHC's and RHC's.

L. Quality of Health Care and Services, Including Access

1. Nebraska requires all HMOs and providers, by contract, to meet state-specified standards for internal quality improvement programs (QIPs).

2. On a periodic or continuous basis, Nebraska monitors the adherence to these standards by all HMOs, through the following mechanisms:

   a. Review of the written QIP for each HMO to monitor adherence to the Nebraska QIP standards. Such review shall take place at least annually.

   b. Periodic review of numerical data or narrative reports describing clinical and related information on health services and outcomes of health care for the Medicaid enrolled population. This data will be submitted to the Department as required by the contract with the HMO.

   c. Monitoring of the implementation of the QIP to ensure compliance with Nebraska QIP standards. This monitoring is conducted on-site at both the HMO administrative offices and the care delivery sites, as necessary. At least one such monitoring visits shall occur per year.

   d. Monitoring through the use of Department personnel and contracted staff.

3. The Department will arrange for an independent, external review of the quality of services delivered under each HMO's contract with the state. The review will be conducted for each HMO contractor on an annual basis. The entity which provides the annual external quality reviews shall not be a part of the state government, an HMO, or an association of any HMOs.

4. Recipient access to care will be monitored as part of each HMO's internal QIP and through the annual external quality review for HMOs. The periodic medical audits, state monitoring activities and the external quality review shall all derive the following information:

   a. Periodic comparisons of the number and types of Medicaid services before and after the institution of the NHC Program.

   b. Recipient satisfaction surveys managed by state staff.

   c. Periodic recipient surveys which the HMOs will conduct containing questions about recipient access to services.

   d. Measurement of waiting periods to obtain health care services; including standards for waiting time and monitor performance against these standards.

   e. Measurements of referral rates to specialists.

f. Assessment of recipient knowledge about how to obtain health care services.

g. Utilization and encounter data submitted by HMOs .

M. Access to Care

Nebraska assures that recipients will have a choice between at least two PCCM PCPs or a combination of one HMO and the PCCM program. When fewer than two choices are available in the geographic area, the managed care program is voluntary. In addition to this process, the NHC program is not likely to substantially impair access because of the following:

1. Recipients may choose any of the participating HMOs or PCCM PCPs in the service areas. In addition, as per 42 CFR 434.29, within an HMO each Medicaid enrollee has a choice of health professional to the extent possible and feasible.

2. The same range and amount of services that are available under the Medicaid fee-for-service program are available for enrollees covered under the NHC Program.

3. Access standards for distances and travel miles to obtain services for recipients under the NHC program have been established. Specifically, the NHC program must have a PCP within 30 miles or 30 minutes.

   The Department utilizes the 30-mile/30-minute guideline for all NHC providers. This is applied to the HMOs at the time they request service to a new county, as well as quarterly thereafter. The Department requires the enrollment broker to review each county for PCP access on a quarterly basis in the PCCM program. This report is submitted to the Department for review.

   The Department realizes that there are rural portions of the state that simply do not have certain specialists within a 30-mile/30-minute radius. In the event of HMO or PCCM expansion, the external quality review organization will review the specialist panel for adequacy. This is based on a knowledge of the existing pool of specialists and whether there are a sufficient number of specialists in the panel of the HMO to service the enrollment level of the area.

   The PCCM option allows the PCP to give a referral to any Nebraska Medicaid provider, thus the panel of specialists would be the entire Nebraska Medicaid provider network. This allows any PCCM enrollee to see any specialist that accepts Nebraska Medicaid. Therefore, this network is no less than the network available to a person not in the NHC program.

   The Department realizes that there are some counties in the state that do not have a hospital. While the normal guideline is to have at least one hospital in the county being served, consideration is given to those counties without a hospital.

Additionally, if a county has multiple hospitals, the Department expects to see a fair representation on the provider network.

4. The number of providers to participate under the NHC program is expected to increase.

5. Primary care and health education are provided to enrollees by a chosen or assigned HMO or PCCM PCP. This fosters continuity of care and improved provider/patient relationships.

6. Pre-authorization is precluded for emergency care and family planning services under the NHC Program.

7. Recipients have the right to change plans at any time if good cause is shown.

8. HMOs and PCCM PCPs are required to provide or arrange for coverage 24 hours a day, 7 days a week.

9. Recipients have available a formal appeals process under 42 CFR Part 431, Subpart E. The same appeals hearing system in effect under the Medicaid fee-for-service program is in effect under the NHC program pursuant to Title 467 NAC.

10. Nebraska assures that state-determined access standards are maintained by quarterly analysis of provider panels.

11. Under the terms and conditions of their existing contracts, HMOs must:

    a. Assure that covered services are accessible to all enrollees, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities.

    b. Provide to enrollees and prospective enrollees: an informational letter written in the applicable language explaining the HMO policies, a toll-free number to obtain further information about the HMO in the applicable language, all enrollment materials written in the applicable language, and translation services when necessary to ensure delivery of covered services.

    c. Inform a non-English-speaking enrollee about any provider who speaks the same non-English language, if the HMO is aware of any such provider.

12. Nebraska has a limit in Title 482 NAC on the number of recipients that can be managed by a physician in the NHC program in effect under the NHC program. The limit guarantees access to appointments within acceptable time parameters for urgent and illness-related conditions as well as non-symptomatic preventive care. The number of Medicaid recipients also allows for the PCP to serve a sufficient number of private-pay and commercially insured patients to create a mixture of patients

reflective of the insurance status of the community may be required.

The Department allows an additional enrollment for PCPs with a physician assistant participating in the program. Contracted HMOs and PCCM's are expected to hold this requirement as part of the evaluation of provider panels for individual counties in which they are approved for participation.